Little Traverse Bay Bands of Odawa Indians Child Care Assistance Program
7500 Odawa Circle-Harbor Springs, MI 49740 Telephone: (231)242-1626, Fax: (231)242-1635

CHANGE OF INFORMATION

APPLICANT/PARTICIPANT NAME:_____

Section I. Personal Information ☐Name Change ☐Address Change ☐Telephone

Name: _____

New Address: _____

Home Telephone: _____ Work Telephone: _____

Section II. Childcare Needs ☐ Addition ☐Deletion

Change of Children Information

Add	Del	Child's Name	Birth date	Social Security #	Sex	Tribal #	Hours needed
☐	☐						
☐	☐						
☐	☐						
☐	☐						
☐	☐						
☐	☐						

Section III. Household Income Information

Change of Income or Household information

	Name	Relationship to Applicant	Monthly Gross	Birth-date	SS #
1					
2					
3					
4					
5					

Section IV. Provider Information

Change of Provider Information

Provider Name: _____

Provider Address: _____

License #* _____ Telephone: _____

Type of Care: ☐ Relative Care ☐ Center Based ☐ Group Child Care

_____ _____

Applicant/Participant Signature ***Date***

****A copy of provider's license, if applicable, and completed W-9, must accompany this application.***